Facility Pre-Admission Screening Form

When admitting a patient/resident, please complete **both pages** to the best of your ability to assist with any care and/or infection control measures that would need to be implemented. Please request copies of any relevant microbiology cultures, pending labs, medication administration record (MAR) or physician order sheet (POS), and immunization documentation.

Patient Information

Last Name _____First Name_____Date of Birth____/____/_____

Symptom History: (check all that apply) ☐DOES NOT APPLY

Is the individual currently experiencing or has had any of the following symptoms in the past 4 months?

Symptoms	If yes, date(s) when experienced	Symptoms	If yes, date(s) when experienced
☐ Fever		☐ Cold sore	
☐ Sore throat		☐ Fever and rash	
☐ Rashes or vesicles on skin		☐ Respiratory symptoms – cough, runny nose etc.	
☐ Open wound		☐ Persistent coughing	
☐ Non-healing wound		☐ Coughing up blood	
☐ Wound drainage		☐ Drainage from eyes, ears	
☐ Soft tissue necrosis		☐ Swollen lymph nodes	
☐ Pressure ulcer on skin		☐ Nausea, vomiting	
☐ Nail wound		☐ Diarrhea	
☐ Skin lesions – boil, cyst etc.		☐ Blood with diarrhea	
☐ Infection at ostomy sites		☐ Other	

Exposure History:

- Has the individual had close contact with a person having a known infection?
  ☐ Yes ☐ No
  If yes, type of infection: _____ Dates of contact: _____
- Has the individual traveled outside the U.S. in the past 21 days (3 weeks)?
  ☐ Yes ☐ No
  If yes, where? _____ Dates traveled: From _____ To _____
- Does the individual have, or have had contacts with animals?
  ☐ Yes ☐ No
  If yes, animal type _____ Dates of contact _____
  Describe interaction:

  _____

Any additional comments:

Person Completing Form (add name here)_____ Date: _____

Inter-facility Infection Prevention Transfer and/or Facility Pre-admission Screening Form

When transferring or admitting a patient/resident, please complete **this page** to the best of your ability to assist with care transitions. **Please send copies (or request copies)** of any relevant **microbiology cultures**, **pending labs, medication administration record (MAR)** or **physician order sheet** (POS), and **immunization records.**

Patient Information

Last Name _____First Name_____Date of Birth_____/_____/_____

Isolation Precautions: CDC guidelines-https://www.cdc.gov/infectioncontrol/guidelines/isolation/appendix/type-duration-precautions.html

The patient currently requires the following type(s) of isolation precautions.

- ☐ Contact precautions. Reason: See organism(s) under Infection/Colonization History section
- ☐ Droplet precautions. Circle Reason: Influenza, other: _____
  - ☐ Suspected or ☐ Confirmed
- ☐ Airborne precautions. Circle Reason: Pulmonary Tuberculosis, Measles, Varicella Zoster Virus**.**
  NOTE: When using Airborne precautions, a verbal report is required.
  - ☐ Suspected or ☐ Confirmed
- ☐ Droplet/Contact. Circle Reason: RSV, parainfluenza, adenovirus, human metapneumovirus, other: _____
- ☐ COVID-19 (use N95 respirator or higher respiratory protection)
- ☐ Enhanced Barrier Precautions. Reason: _____
- ☐ **The patient DOES NOT require isolation.**

Infection/Colonization History: (check all that apply) ☐DOES NOT APPLY

- ☐ MRSA (Methicillin-resistant *Staphylococcus aureus*) or ☐ VRE (Vancomycin-resistant enterococci)
- ☐ *Clostridioides difficile*
- ☐ *Candida auris*
- ☐ Any MDRO gram-negative bacteria (multidrug-resistant). If known, please also specify:
  - ☐ Carbapenem-resistant *Enterobacterales* (examples: *Klebsiella* or *E. coli* with KPC, NDM-1)
  - ☐ *Acinetobacter*, multidrug-resistant
  - ☐ ESBL (extended spectrum beta-lactamase) bacteria
  - ☐ *Pseudomonas aeruginosa*, multidrug-resistant
  - ☐ Other: _____

Immunizations:

☐ Influenza (date) _____

☐ Pneumococcal (indicate type– PCV13, PCV15, PCV20, and/or PPSV23 and date/s) _____

☐RSV (date) _____☐COVID-19 (last date) _____

☐ Shingrix (date) _____

Lab Results: ☐ In chart ☐ Pending results (list) _____

Antibiotics: ☐ Patient not on ABX ☐Antibiotic _____ Start date:_____Stop date:_____

Sending Facility: Person Completing Form (add name here)_____

Facility Contacts	Contact Name	Phone
Transferring RN/Unit		
Infection Preventionist		